Cook County Department of Public Health Quarterly Report to the Cook County Board of Commissioners in their capacity as the Cook County Board of Health

**Q2 2025: CCDPH Nursing Unit Initiatives** Item 25-2513

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# Public Health Nursing



# **Nursing Programs**

- APORS/High-Risk Infant Program: Public Health Nurses provide home visits to assess the home environment, conduct a nutritional evaluation/education, conduct developmental screenings, monitor vaccine compliance, and provide case management services for high-risk infants, and young children.
- Lead Program: Public Health Nurses case manage children and pregnant women with elevated blood lead levels of 3.5ug/dL or greater referred by the IDPH to ensure elimination of lead sources from the environment. Case management includes age and developmentally appropriate family education about the sources of lead, screening and intervention for developmental delays, appropriate nutrition, and return elevated blood lead level results to levels below 3.5ug/dL.
- **TB Prevention and Control Program:** Screen for high-risk TB clients, provide treatment for latent TB infections and active TB disease including the provision of direct observed therapy, and case management services for clients diagnosed with active TB.



# Nursing Programs (Cont'd)

- Breast and Cervical Cancer Screening Program: A statewide grant program for women 40 years of age and older who are uninsured or underinsured that allows them to receive clinical breast exams, mammography, and pap smears.
- Genetics Newborn Follow-up Program: Public Health Nurses ensure that an infant/family who has been identified with potential genetic conditions are referred for specialized genetic testing services including treatment, support, and counseling, thereby promoting health, and minimizing morbidity.
- **Perinatal Hepatitis B Prevention Program:** The goal is the prevention of Hepatitis B transmission from infected mothers to infants through the identification of Hepatitis B surface antigen (HBsAg)-positive pregnant women and their infants and then provide case management and follow-up of the infants, household and sexual contacts.
- Vision and Hearing Screening Program: Provides vision and hearing screening in response to referrals from preschools and grammar schools for children over the age of three. This is done by a Technician.

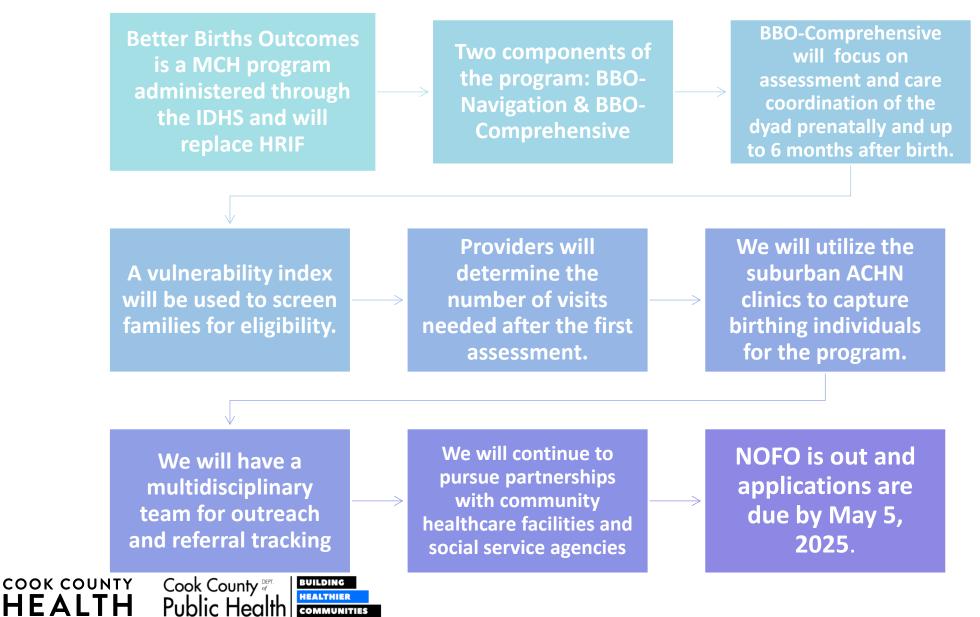


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### **BBO Transition**



### **Collaboration is Key**

Our BCCP program contracts with community health care facility vendors in addition to CCH for the provision of lab, Mammography and screening exams We receive referrals from the Communicable Disease unit for women who are positive for Perinatal Hepatitis B. Nursing then provides Case Management.

Our TB team and Nurse Epidemiologist work with CD also We work side by side with our Emergency Preparedness Unit in the provision of Pop-Up clinics for seasonal vaccine administration and community responses for disease outbreak incidents

We team up with our Environmental Unit to provide home visits within our Lead program. The nurse and the Lead Risk Assessor work in tandem to provide health education, case management, lead hazard remediation and referrals into the Health Homes program

We participate with SCC preschools for hearing and vision screening exams. We developed an electronic request form for school administrators to request services electronically Our Communications unit plays an integral part in website development, formatting content, dissemination of information on multiple social media platforms, along with assisting in the creation of brochures and palm cards

### **Data That Informs**





# **Hearing & Vison Screening**

Total # of children screened for hearing (by age)						
3 у/о	4 y/o	5 y/o	Kindergarten	Total screened for hearing		
923	1026	350	14	2313		

E	Total # of children screened for vision (by age)					
	3 y/o	4 y/o	5 y/o	Kindergarten	Total screened for vision	
FELOPZD DEFPOTEO	856	986	332	11	2185	

\*September 2024 – March 2025



### **Epidemiology: CCDPH Atlas Informing MCH Focus**

(Each of the indicators gives the time-period covered; where the data is available~ municipality, zip code; the data source (most from IDPH), race of the individuals)

Maternal care ED Visits		Maternal mortality rate/Infant mortality rate		Infants born with birth defects		Pre-pregnancy obesity rate		VBAC rate		
ETOH use during pregnancy			Gestational Hypertension		e births	births Cesarian birth rate		Smoking during Pregnancy		
Gestational Diabetes		Infants breastfed at discharge		Early and adequate PN care by race			Very Pre-Term Birth Rate			
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### Maternal Mortality rate

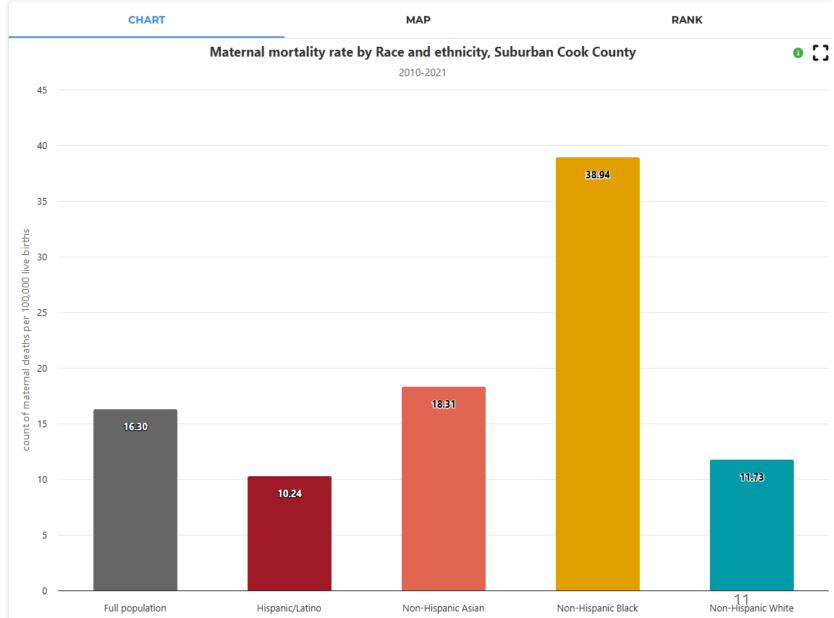
Number of maternal deaths per 100,000 live births; by race/ethnicity

https://cookcountyhealthatlas.org/indicators/JG 8GUIL?topic=maternal-mortality-rate



#### Maternal mortality rate

count of maternal deaths per 100,000 live births Number of maternal deaths per 100,000 live births



### No Prenatal Care Rate

Percent of pregnant persons who did not receive prenatal care among live births by race/ethnicity

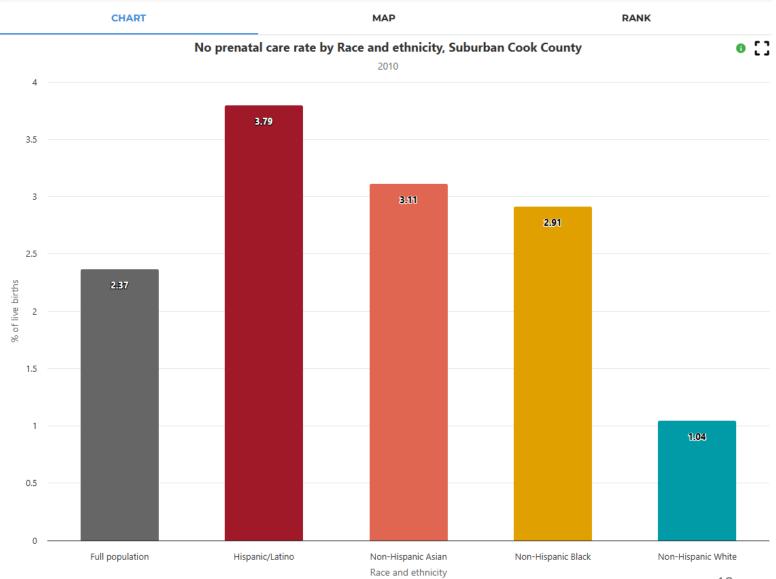
https://cookcountyhealthatlas.org/indic ators/JG8EWAC?topic=no-prenatalcare-rate



#### No prenatal care rate

% of live births

Percent of pregnant females who did not receive prenatal care among live births



### **MATERNAL MORTALITY IN ILLINOIS**

Pregnancy-related deaths

**888** 

Pregnancy-related deaths increased by 40% in Illinois from 2015-2017 to 2018-2020

About 88 women die each year while pregnant or within one year of pregnancy

90% are preventable

BLACK WOMEN HAVE THE HIGHEST RISK OF PREGNANCY-RELATED DEATH





Black women are 2-3X as likely to die from a pregancy-related condition than white women.



High-poverty counties had higher rates of pregnancyrelated deaths than lowpoverty counties.

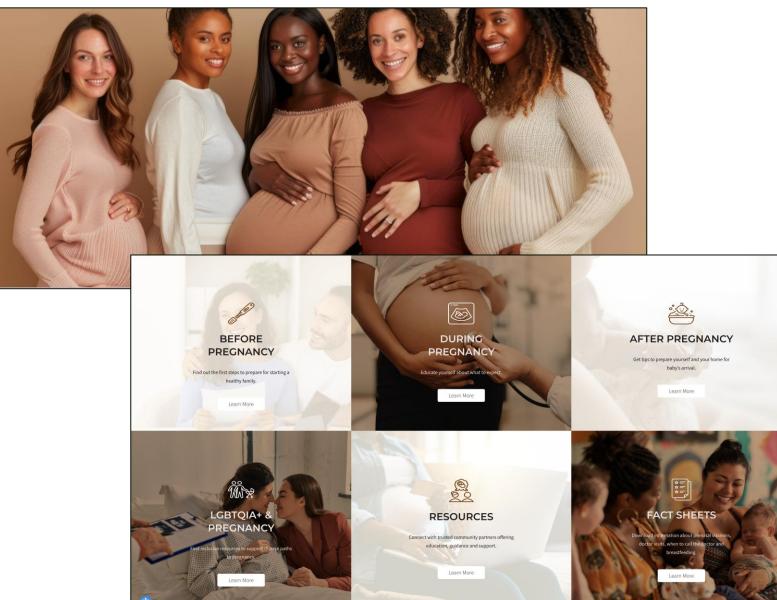


### **Every Mother Every Child Website**

Our nurses developed <u>EveryMotherEveryChild.org</u> for every stage of pregnancy, regardless of gender identity or sexual orientation.

(Since the December 2024 launch, there have been 4524 views and 720 active users)





### Multilingual Educational Tools

- Fact sheets
  - o Prenatal vitamins/nutrition
  - Doctor visit checklist
  - o Breastfeeding
  - English, Spanish, Polish, Arabic, and Simplified Chinese
- Resources
  - Connect with partners offering education, guidance and support
  - Includes links to websites and videos







### Nursing Mobilization During Disease Outbreaks

- The Incident Command System (ICS) is activated under the direction of the COO
- Nursing relies upon activation of this system to guide coordination and control of identified incidences. (most recently Measles)
- PH nurses are called upon to provide testing, take blood samples, administer OTC tests, administer needed vaccines, provide follow-up care, and patient education

### **Seasonal Vaccine Clinics**

TOTALS BY CLINIC	COVID	FLU
Blue Island Health Center	153	132
Robbins Health Center	106	89
Cottage Grove Health Center	179	191
Arlington Heights Health Center	244	202
North Riverside Health Center	272	215
TOTAL	954	829

**October 2024 – March 2025** 

\*Total 1,783



### Legislative Watch/Support

With over 35 counties classified as maternity care deserts, CCDPH supports HB 2688, Nurse Practice Act-Midwives, which is a legislative proposal that empowers CNM's with Full Practice Authority (FPA) to improve and expand maternal care access.

Expansion of the Medicaid Provider Base to include Doulas, Lactation Consultants; Home Visiting Nurses

Healthy School Meals: An appropriation to implement the Healthy School Meals for All Act(PA 103-0532)which allows participating school districts to provide free lunch to all students and be reimbursed at the federal rate.

Support efforts to increase funding for Early Intervention to increase access to services. 4% receive services, although research indicates 13% are eligible.

Cannabis and mandatory DCFS referrals. Currently researching this policy.





### Thank you



